APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 92-3678

ABBAS ASSAR, M.D.,
Plaintiff-Appellant,

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION (CIMRO),
Defendants-Appellees.

Appeal from the United States District Court for the Central District of Illinois, Danville Division
No. 92 C 2161—Harold A. Baker, *Judge*

ARGUED MAY 12, 1993—DECIDED DECEMBER 29, 1993

Before BAUER, KANNE and ROVNER, *Circuit Judges.*

ROVNER, *Circuit Judge.* Crescent Counties Foundation for Medical Care ("CCFMC") is a peer review organization ("PRO") under contract with the Health Care Financing Administration ("HCFA") to review the medical care provided by physicians and hospitals participating in

the Medicare program. *See* 42 U.S.C. §§ 1320c *et seq.*[1] Central Illinois Medical Review Organization ("CIMRO"), also a PRO, subcontracts with CCFMC to perform peer review services for HCFA.[2] Dr. Abbas Assar seeks damages from CCFMC and CIMRO, alleging that CIMRO failed to follow proper statutory and regulatory procedures when it found him in violation of certain quality of care requirements. The district court dismissed the suit for lack of subject matter jurisdiction, and we affirm.[3]

I. Background

Health care providers who participate in the Medicare program are statutorily required to "assure" that their services:

> (1) will be provided economically and only when, and to the extent, medically necessary;
>
> (2) will be of a quality which meets professionally recognized standards of health care; and
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> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

42 U.S.C. § 1320c-5(a); *see also* 42 C.F.R. § 1004.10. PROs review the services of participating providers to insure compliance with these statutory obligations. Possible sanctions for non-compliance include exclusion from

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[1] Because CIMRO made the now-contested finding regarding Assar in August 1989, we will rely on the 1988 statute and regulations, which were in effect at that time.

[2] 42 U.S.C. § 1320c-2(c)(1) authorizes such subcontracting.

[3] Although some courts as well as the parties and the district court in this case have framed the issue as one of subject matter jurisdiction, other courts have understood it as failure to state a claim. Because the result is the same either way, the distinction is not significant.

the Medicare program. 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.20; *see also* 42 U.S.C. § 1320c-2(c)(1).

The statute and regulations set out an elaborate procedure for finding non-compliance. *See* 42 U.S.C. § 1320c-5; 42 C.F.R. §§ 1004.30-1004.80. That process is set into motion when the PRO determines that a provider either has "failed in a substantial number of cases substantially to comply" with the statutory obligations or has "grossly and flagrantly violated any such obligation in one or more instances." 42 U.S.C. § 1320c-5(b)(1); *see also* 42 C.F.R. § 1004.30(c). Upon making that determination, the PRO must notify the provider in writing of both the basis for the determination and the proposed sanction. The provider then has thirty days to submit additional information or to request a meeting to discuss the PRO's determinaion (42 C.F.R. § 1004.50),[4] and the PRO may reconsider its decision in light of any additional information (42 C.F.R. § 1004.50(c)). If the PRO persists in its determination, it must submit a report and recommendation to the Office of the Inspector General ("OIG") (42 C.F.R. §§ 1004.60-1004.80) and must send the provider a copy of its report (42 C.F.R. § 1004.60(b)). The provider once again has thirty days to submit additional information, this time to OIG. 42 C.F.R. § 1004.60(b)(2). OIG then reviews the determi-

[4] When the PRO finds a "substantial violation in a substantial number of cases," the regulations outline an additional procedure, which includes sending a "written *initial* notice of the identification of a violation." 42 C.F.R. § 1004.40(b) (emphasis added). That notice must indicate the proposed sanction and must give the provider twenty days to submit additional information or request a meeting to discuss the determination. 42 C.F.R. §§ 1004.40(b)(5) & (6). The notice might also include, at the PRO's discretion, a suggestion for corrective action. 42 C.F.R. § 1004.40(b)(4). The 1988 regulations did not provide for corrective action in the case of "gross and flagrant" violations. Pursuant to a 1992 amendment, 42 C.F.R. § 1004.50(b)(4) now directs the PRO to suggest corrective action, "if appropriate," for either a "substantial" or a "gross and flagrant" violation.

nation and recommended sanction (42 C.F.R. § 1004.90) and notifies both the provider and the public of its decision (42 C.F.R. § 1004.100). Finally, the regulations provide:

> The determination and notice of sanction provided for in this section constitute an "initial determination" and a "notice of initial determination" for purposes of the administrative appeals procedures specified in Part 498 of this title concerning determinations and appeals procedures for providers and suppliers.

42 C.F.R. § 1004.100(g).

Part 498 in turn sets out a procedure for administrative review. First, the provider may request reconsideration by HCFA. 42 C.F.R. § 498.22. He may then request a hearing before an administrative law judge (42 C.F.R. §§ 498.40-498.78), whose decision is subject to review by an Appeals Council (42 C.F.R. § 498.80-95). After completing the administrative review process, the provider may file a civil action in federal district court pursuant to 42 U.S.C. § 405(g). 42 U.S.C. § 1320c-5 (4); 42 C.F.R. § 498.103.

Between 1986 and 1991, CIMRO reviewed the medical services Assar provided to Medicare beneficiaries.[5] In August 1989, CIMRO found that Assar had committed a gross and flagrant violation[6] and as a result required him to obtain a second opinion before performing any non-emergency surgery. (Complaint at Count I

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[5] This factual summary derives from Assar's First Amended Complaint ("Complaint"). We adopt his version of the facts in considering defendants' motion to dismiss.

[6] The violation related to an elderly patient, whose death CIMRO's report attributed to inappropriate emergency room care. According to the report, Assar may have been at least partially responsible for that care. The report also includes several additional less serious violations. (Complaint Ex. 1 at 3).

¶¶ 7, 13). CIMRO, however, did not provide Assar with written notice as required by 42 C.F.R. § 1004.50 and did not submit a report to OIG as required by 42 C.F.R. § 1004.70. The latter failure, according to Assar, prevented the administrative review process from going forward.[7] He thus claims that CIMRO "constructively and effectively prevented him from appealing its decisions either through administrative review or judicial review." (Complaint at Count I ¶ 14). He also claims that CIMRO acted beyond its authority when it imposed "practice restrictions" (*id.* at Count I ¶ 12; *see supra* n.7) and that CIMRO published false and defamatory statements about him in violation of 42 U.S.C. § 1320c-9[8] and 42 C.F.R. §§ 476.107 & 476.139. (Complaint at Count I ¶ 10). Assar asserts that he "has exhausted all administrative appeal remedies by sending multiple re-

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[7] The defendants assert that CIMRO did not follow these steps because Assar had agreed to participate in a corrective action plan (receiving the second surgical opinions) in order to avoid being excluded from the Medicare program. They claim that if Assar had not agreed to participate in the corrective action plan, the report and recommendation would have been sent to OIG and the administrative review process would thereby have been set into motion. Assar argues that the PRO had no authority to institute a corrective action plan because the 1988 regulation did not provide that option for "gross and flagrant" violations. Defendants respond that despite the absence of regulatory authorization, HCFA's policy was to allow corrective action plans for "gross and flagrant violations" even before the regulation was amended. (*See* Complaint Ex. 6 at 2). This dispute is irrelevant for purposes of defendants' motion to dismiss, as to which we must make all factual inferences in Assar's favor.

[8] 42 U.S.C. § 1320c-9(a) provides that "[a]ny data or information acquired by any [PRO] in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person . . . ," with various enumerated exceptions related to the Act's purpose. Subpart (c) of the section provides that "any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months . . . ."

quests to CIMRO and its attorney as well as the Department of Health and Human Services, Health Care Financing Administration . . . requesting appeals, hearings, and reviews of the illegal PRO actions . . . which were subsequently denied . . . ." (*Id.* at Count I ¶ 15).

All parties agree that there was no final administrative decision here that would have been reviewable in federal district court under 42 U.S.C. § 405(g). Instead, Counts I and II of Assar's complaint purport to arise "under Part B of Title XI and Title XVIII as well as other parts of the Social Security Act" and do not assert any other basis for federal jurisdiction. (Complaint at Count I ¶ 1, Count II ¶ 1). Count III asserts a Fifth Amendment due process claim and cites 28 U.S.C. § 1331 as the basis for federal jurisdiction. All three counts seek compensatory and punitive damages.

II. Counts I and II

The basis for the first two counts of Assar's complaint is not immediately apparent. The Social Security Act contains no provision expressly authorizing damages actions against PROs, and Assar's complaint does not cite any particular provision as giving rise to such an action. Be that as it may, the district court did not directly address the basis for Counts I and II, but focused only on Assar's Count III due process claim.[9] Assar did not contest the court's decision in a post-judgment motion and has addressed only the constitutional claim on appeal.[10]

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[9] After concluding that no remedy was available for the alleged due process violation, the district court stated, "there is no other basis for federal jurisdiction either alleged or available." *Assar v. Crescent Counties Found*, No. 92-2161, slip op. at 7 (C.D. Ill. Oct. 6, 1992).

[10] Assar's jurisdictional statement on appeal states, "[t]his case arises under the Constitution and, therefore, the District Court had jurisdiction under 28 U.S.C. § 1331." He does not articulate any theory under which the Social Security Act itself might give rise to a private damages action. Perhaps he means to do so when

Having failed to challenge the dismissal of Counts I and II on appeal, Assar has apparently acquiesced in the district court's implicit decision that these counts stated no viable cause of action.

III. Count III

Assar attempts to rest Count III on the Fifth Amendment, relying on the theory first articulated in *Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics,* 403 U.S. 388 (1971). There, the Supreme Court held that individuals whose Fourth Amendment rights had been violated by federal officers could sue for money damages in federal court. The Court found "no special factors counselling hesitation in the absence of affirmative action by Congress" (*id.* at 396) and noted the absence of any "explicit congressional declaration that persons injured by a federal officer's violation of the Fourth Amendment may not recover money damages from the agents, but must instead be remitted to another remedy, equally effective in the view of Congress" (*id.* at 397). *See also Davis v. Passman,* 442 U.S. 228, 246-47 (1979).

In *Bush v. Lucas,* 462 U.S. 367, 378 (1983), the Court summarized the considerations that are relevant in determining whether damages are available for constitutional violations by federal actors:

> When Congress provides an alternative remedy, it may of course, indicate its intent, by statutory language, by clear legislative history, or perhaps even by the statutory remedy itself, that the courts' power should not be exercised. In the absence of such a congressional directive, the federal courts must make

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ne cites 42 U.S.C. § 1320c-6 (*see* Assar brief at 16-20), but he has failed to explain how this provision—which appears to do nothing more than bar or limit civil or criminal liability of various individuals or entities under certain circumstances—would *give rise to* a federal cause of action.

> the kind of remedial determination that is appropriate for a common-law tribunal, paying particular heed, however, to any special factors counseling hesitation before authorizing a new kind of federal litigation.

In *Bush*, a federal civil servant who alleged that he had been wrongfully discharged in retaliation for exercising his first amendment rights sued for damages. Although the Court noted that Congress had neither expressly precluded a damages remedy nor provided an equally effective alternative (*id.*), it nonetheless found "special factors counselling hesitation." The Court concluded that "special factors" related to "the question of who should decide whether such a remedy should be provided" (*id.* at 380) and, in light of the administrative review process that was already in place, explained:

> The question is not what remedy the court should provide for a wrong that would otherwise go unredressed. It is whether an elaborate remedial system that has been constructed step by step, with careful attention to conflicting policy considerations, should be augmented by the creation of a new judicial remedy for the constitutional violation at issue. That question obviously cannot be answered simply by noting that existing remedies do not provide complete relief for the plaintiff.

Id. at 388. Finding ultimately that "Congress is in a better position to decide whether or not the public interest would be served by creating" a damages remedy, the Court declined to do so. *Id.* at 390.

In *Schweiker v. Chilicky*, 487 U.S. 412 (1988), the Court explored *Bivens* and its progeny in a context very similar to our own. Plaintiffs who had been denied social security benefits sought damages for alleged due process violations. Summarizing its own post-*Bivens* case law, the Court explained:

> [T]he concept of "special factors counselling hesitation in the absence of affirmative action by Congress" has proved to include an appropriate judicial deference to indications that congressional inaction has not been inadvertent. When the design of a Government program suggests that Congress has provided what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration, we have not created additional *Bivens* remedies.

Id. at 423. The Court noted that the Social Security Act provided for several levels of administrative review and for subsequent judicial review, which would include review of constitutional claims, under 42 U.S.C. §§ 405 (g) & 421(d). Although that process did not offer complete relief—damages for constitutional violations were unavailable—the Court found that Congress "has not failed to provide meaningful safeguards or remedies for the rights of persons situated as respondents were." *Id.* at 425. It further reasoned that "[i]n light of the comprehensive statutory scheme[] involved, the harm resulting from the alleged constitutional violation can[not] be separated from the harm resulting from the denial of the statutory right." *Id.* at 428. The Court thus concluded:

> Whether or not we believe that its response was the best response, Congress is the body charged with making the inevitable compromises required in the design of a massive and complex welfare benefits program. Congress has discharged that responsibility to the extent that it affects the case before us, and we see no legal basis that would allow us to revise its decision.

Id. at 429 (citations omitted).

Relying on *Chilicky*, the Tenth Circuit in *Hilst v. Bowen*, 874 F.2d 725 (10th Cir. 1989) (per curiam), dismissed a complaint very similar to Assar's. In that

case, a physician sought damages for due process violations that allegedly had occurred when he was suspended from the Medicare program for falsifying claim forms and providing unnecessary services. Although administrative review ultimately cleared him of those charges, Hilst claimed that he should have been reinstated in the program during the pendency of his appeal. The court did not allow his *Bivens* action, reasoning:

> In this case, a comprehensive remedy is provided to physicians when their right to participate in the Medicare program is suspended. As in *Chilicky,* this remedy includes an elaborate administrative hearing, and administrative and judicial review. Although this remedial framework does not provide Hilst with consequential damages arising from defendant's unconstitutional conduct, the Court in *Chilicky* clearly indicated that this lack does not entitle a plaintiff to maintain a *Bivens* action so long as the remedy, although incomplete, is adequate and the safeguards are meaningful. We believe that the reasoning of *Chilicky* is applicable here and precludes Hilst from pursuing a *Bivens* action.

Id. at 727-28 (citations omitted).

As was true in *Chilicky* and *Hilst,* Congress has created a comprehensive scheme by which physicians can obtain review of PRO decisions affecting their participation in the Medicare program. As in those cases, the harm resulting from the alleged constitutional violation is indistinguishable from the harm resulting from the denial of the statutory right. The fact that the particular remedy Assar seeks is unavailable under the existing framework does not justify creation of a *Bivens* remedy. *See Feit v. Ward,* 886 F.2d 848, 854 (7th Cir. 1989).

Assar argues that his case is distinguishable from *Chilicky* and *Hilst* because CIMRO prevented his participation in the remedial scheme that was available by failing

to submit a report and recommendation to OIG.[11] But our decision today addresses only the availability of a *damages* remedy, which is the sole relief that Assar has requested. He has not sought to compel CIMRO's compliance with the regulations.[12]

IV. Conclusion

No *Bivens* remedy is available to Assar in light of the comprehensive remedial scheme set forth in the statute and regulations. The district court's dismissal of Assar's complaint is AFFIRMED.

A true Copy:

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Clerk of the United States Court of
Appeals for the Seventh Circuit

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[11] As already noted, the defendants dispute Assar's factual assertions (*see* n.7), but that factual dispute is irrelevant for our purposes.

[12] He might, for example, have sought relief under 28 U.S.C. § 1361, the federal mandamus statute, which provides:

> The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

Although we are not now asked to decide whether such relief is available in these circumstances, we did hold in *Burnett v. Bowen*, 830 F.2d 731, 738 (7th Cir. 1987), that "Congress intended to preserve mandamus jurisdiction for claims that are procedural in nature under the Social Security Act." Assar seems to acknowledge the availability of mandamus relief when he states that "28 U.S.C. § 1361 is not the exclusive or mandatory avenue by which Plaintiff must pursue claims against the PRO." (Assar Brief at 13).

APPENDIX B

[Filed Oct. 6, 1992]

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS

Case No. 92-2161

ABBAS ASSAR,

Plaintiff,

vs.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,

Defendants.

ORDER

The plaintiff, Dr. Abbas Assar, seeks compensatory and punitive damages for common law torts and for denial of due process under the Fifth Amendment. The defendants, Crescent Counties Foundation for Medical Care ("CCFMC") and Central Illinois Medical Review Organization ("CIMRO"), have each moved to dismiss the plaintiff's claims under Fed. R. Civ. P. 12. For the reasons set forth below, the court grants the defendants' motions.

FACTS

The plaintiff is a licensed physician practicing medicine and residing in Illinois. The defendants are "utilization and quality control peer review organizations (PROs)" created pursuant to the Social Security Act, at 42 U.S.C. § 1320 (1991).[1] A PRO contracts with the Department of Health and Human Services to review

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[1] All references in this order to the United States Code and Code of Federal Regulations are to the 1991 editions of these publications.

the provision of medical care to Medicare beneficiaries by physicians and hospitals participating in the Medicare program. Under 42 U.S.C. § 1320c-1, a PRO is to perform reviews which are based on objective criteria and which are designed to assure that services to beneficiaries under the Act:

> (1) will be provided economically and only when, and to the extent, medically necessary;
>
> (2) will be of a quality which meets professionally recognized standards of health care; and
>
> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

If a PRO determines that a health care provider may have failed to comply with any of these requirements, then the PRO must provide "reasonable notice and opportunity for discussion with the practitioner or person concerned." 42 U.S.C. § 1320c-5(b)(1).[2]

Once the PRO determines that the practitioner has either failed in a substantial number of cases to comply with any obligation under the Act or "grossly and flagrantly violated any such obligation in one or more instances," then the PRO "shall submit a report and recommendations to the Secretary." *Id.*; 42 C.F.R. § 1004.30 (c). If the PRO determines that the violation is one that is gross and flagrant, then under 42 C.F.R. §§ 1004.40(a), 1004.50, the PRO must give written

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[2] For initial determinations made by a PRO after Nov. 5, 1990, the Act further states that a PRO should also provide, "if appropriate, . . . a reasonable opportunity to enter into and complete a corrective action plan." *Id.* (as amended by Pub. L. 101-508, §§ 4205(a)(1)((A), 4205(a)(2) (1990)). However, the alleged initial determination in this case was made in August, 1989, prior to the effective date of this amendment.

notice to the practitioner or other person which states the following information:

> (1) The determination of a violation.
>
> (2) The obligation violated.
>
> (3) The basis for the determination.
>
> (4) The sanction the PRO will recommend to the OIG.
>
> (5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. . . .
>
> (6) A copy of the material used by the PRO in arriving at its determination.

The PRO then must reconsider its determination and either affirm, modify, or reverse its earlier determination, and give the practitioner written notice of any action that it takes based upon any additional information received. *Id.* If the issue is not resolved by the PRO at this stage, then the PRO must submit a report and recommendation to the Secretary (through the Office of the Inspector General, or "OIG"). 42 U.S.C. § 1320c-5(b)(1). If the OIG affirms the PRO's recommendation, then the OIG may impose sanctions, such as excluding the practitioner from eligibility to provide services under Medicare.[3] The Act then provides for several levels of appeal. It first provides for a hearing with an administrative law judge, then review of that decision by an Appeals Coun-

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[3] For initial determinations by a PRO prior to Nov. 5, 1990, in order to impose a sanction, the OIG must find that "such practitioner or other person . . . has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations." 42 U.S.C. § 1320c-5(b)(1) (as amended by Pub. L. 101-508, §§ 4205(a)(1)(B), 4205(a)(2) (1990)). This amendment postdates the alleged initial determination in the case at hand.

cil, and finally judicial review in a civil action, if appropriate.

The defendant CCFMC contracted with the federal government to perform reviews of medical services pursuant to the Act. The defendant CIMRO subcontracted with CCFMC.

In early August, 1989, CIMRO performed a review of the plaintiff's provision of medical care to a Medicare patient and allegedly issued a gross and flagrant quality of care deficiency against the plaintiff. On September 6, 1989, CIMRO allegedly imposed practice restrictions and limitations against Dr. Assar limiting his rights and abilities to care for Medicare patients under the federal Medicare program. The plaintiff first claims that these restrictions have effectively excluded him from participation in the Medicare program and that the imposition of these "sanctions" exceeded the authority of the defendants. The plaintiff then claims that, upon the August, 1989 finding of a "gross and flagrant" deficiency, the defendants were required to submit a report and recommendation to the OIG which would initiate administrative review of the defendants' actions. Because the defendants have allegedly failed to submit a report to the OIG, the plaintiff asserts that he is essentially caught in a "Catch-22." He claims he is unable to pursue an administrative appeal due to the defendants' unlawful inaction, and yet he cannot obtain judicial review of this unlawful inaction because of his failue to exhaust administrative remedies.

In Counts I and II of his amended complaint, Dr. Assar alleges that CIMRO and CCFMC, through CIMRO, negligently and maliciously failed to comply with review procedures and guidelines, reporting requirements, and nondisclosure rules, and furthermore that CIMRO published defamatory statements, acted manifestly and palpably beyond its authority, acted without due care, and acted in retaliation for previous disputes with CIMRO. In Count III, Dr. Assar claims that, by

imposing sanctions outside their authority and preventing administrative review of these actions by failing to submit a report to the OIG, the defendants' actions constituted an intentional denial of Plaintiff's Fifth Amendment right to due process.

ANALYSIS

Subject matter jurisdiction must be pled and established by the party invoking it. Fed. R. Civ. P. 8(a). The plaintiff's amended complaint states that the action "arises under the Fifth Amendment of the United States Constitution" and "under Part B of Title XI and Title XVIII as well as other parts of the Social Security Act." For the constitutional claim asserted in Count III, the plaintiff pleads federal question jurisdiction under 28 U.S.C. § 1331. In the plaintiff's Brief in Reply to Defendants Motion to Dismiss, at 4-5, the plaintiff cites *Bivens v. Six Unknown Federal Narcotics Agents,* 403 U.S. 388 (1971), as the "controlling case" regarding his constitutional claim.

The Supreme Court decision in *Bivens* generally stands for the proposition that a private cause of action for damages may exist in federal court for victims of constitutional violations by federal officers acting under color of their authority. In subsequent decisions, a *Bivens* action has been permitted under 28 U.S.C. § 1331 where there are "no 'special factors counselling hesitation in the absence of affirmative action by Congress,' no explicit statutory prohibition against the relief sought, and no exclusive statutory alternative remedy." *Schweiker v. Chilicky,* 487 U.S. 412, 421 (1987) (citing *Davis v. Passman,* 442 U.S. 228, 246-47 (1979), and *Carlson v. Green,* 446 U.S. 14, 18-20 (1980)). Whether this Court has jurisdiction to hear Dr. Assar's claims depends initially on whether Congress has precluded federal question jurisdiction over a *Bivens* action for constitutional violations of the Social Security Act.

In 42 U.S.C. § 1395ii, Congress makes 42 U.S.C. § 405(h) of the Social Security Act applicable to the Medicare program. Section 405(h) provides that:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Under *Weinberger v. Salfi*, 422 U.S. 749 (1975), this provision was interpreted to bar federal question jurisdiction of a suit challenging the constitutionality of a provision in the Act, where the plaintiffs sought declaratory and injunctive relief as well as damages equivalent to the Social Security benefits denied by the Secretary based on the challenged provision. The plaintiffs argued that their action arose under the Constitution and not under the Social Security Act. *Id.* at 760. The Court held that the claim arose under *both* the Constitution and the Social Security Act: "For not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions." *Id.* at 760-61. However, the impact of the decision in *Weinberger* on the question of whether § 405(h) precludes a *Bivens* remedy is unclear. The Supreme Court noted in *Chilicky*, 487 U.S. at 429 n.3 (citing *Weinberger*, 422 U.S. at 756-62; *Heckler v. Ringer*, 466 U.S. 602, 614-16, 620-26 (1984); *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 679 (1986)), in an action where the plaintiffs sought consequential damages for hardships resulting from an allegedly unconstitutional denial of Social Security

benefits, that "the exact scope of the third sentence's restriction [in § 405(h)] on federal-question jurisdiction is not free from doubt; because we hold on other grounds that a *Bivens* remedy is precluded in this case, we need not decide whether § 405(h) would have the same effect." The Supreme Court has thus reserved the question of whether a plaintiff may bring a *Bivens* action in federal court for a constitutional claim based on violations of the Social Security Act.

In *Bodimetric Health Servs., Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 488-490 (7th Cir. 1990), where the plaintiff sought damages for common law torts allegedly committed by a fiscal intermediary under the Medicare program, the Seventh Circuit interpreted the scope of the jurisdictional restriction in § 405(h), but only to the extent that it found § 405(h) precluded a federal district court from review of a claim based on diversity jurisdiction. The court noted that:

> A party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Id. at 487 (citations omitted). While the court was not presented with a plaintiff alleging a constitutional claim, the court's hesitancy to find jurisdiction in cases involving Medicare argues against this court asserting jurisdiction over Dr. Assar's claims.

Regardless of whether § 405(h) precludes a *Bivens* remedy, this court holds that a *Bivens* remedy is not available for alleged due process violations in the exclu-

sion of a Medicare provider from the Medicare program. Under *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1241-3 (7th Cir. 1981), the Seventh Circuit determined that a Medicare provider has a constitutionally-protected property right in the expectation of continuing participation in the Medicare program. Thus, the primary issue before this court is whether a *Bivens* remedy is appropriate for alleged due process violations in the exclusion of a Medicare provider from the Medicare program.

In *Bivens*, the court fashioned a remedy for the plaintiff where there were "no special factors counselling hesitation in the absence of affirmative action by Congress," and "no explicit congressional declaration" that money damages could not be awarded. *Bivens*, 403 U.S. at 396-97. Recently, in addressing the appropriateness of a *Bivens* action for alleged due process violations in the denial of social security disability benefits, the Court stated that:

> In sum, the concept of 'special factors counselling hesitation, in the absence of affirmative action by Congress' has proved to include an appropriate judicial deference to indications that congressional inaction has not been inadvertent. When the design of a Government program suggests that Congress has provided for what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration, we have not created additional *Bivens* remedies.

Chilicky, 487 U.S. at 423. The Court held that a *Bivens* remedy was unavailable due to the "comprehensive statutory scheme" created by Congress to "address[] the problems created by state agencies' wrongful termination of disability benefits." *Id.* at 428-29. The case before this court is virtually indistinguishable from *Chilicky*. Thus, as the design of the Medicare program within the Social Security Act suggests that Congress has provided ade-

quate remedial mechanisms for constitutional violations in the administration of the program, this court holds that a cause of action under *Bivens* for just such constitutional violations is not available.

Just as the Social Security Act "makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful denial of benefits," *id.* at 424, the Medicare program within the Social Security Act also makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful exclusion of a practitioner from participation in the Medicare program. Once such a practitioner's participation in the Medicare program is fully restored through the administrative process, that practitioner lacks standing for an action based on the Constitution under the statute's administrative review provisions. As in *Chilicky*, while the "creation of a *Bivens* remedy would obviously offer the prospect of relief for injuries that must now go unredressed," Congress "has not failed to provide meaningful safeguards or remedies for the rights of persons wrongfully deprived of participation in the Medicare program. *Id.* at 425.[4] The Social Security Act includes detailed statutory mandates providing for several levels of administrative review of the actions of PROs and the sanctioning of a Medicare provider. Where a PRO or any other federal official obstructs this process or fails to comply with these statutory requirements, then a federal district court may issue a mandamus to compel compliance with these laws under 28 U.S.C. § 1361. "In

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[4] *See also Feit v. Ward*, 886 F.2d 848, 854 (7th Cir. 1989) ("Simply stated, the Supreme Court's rationale in *Chilicky*, particularly the Court's analysis of *Bush v. Lucas*, makes clear that under the 'special factors' analysis, determining whether the *particular* remedies available to the plaintiff claiming a violation of his constitutional rights are meaningful and adequate is unnecessary." (emphasis in original)).

light of the comprehensive statutory schemes involved, the harm resulting from the alleged constitutional violation [cannot] be separated from the harm resulting from the denial of the statutory right." *Id.* at 428.

As a *Bivens* remedy is not available to the plaintiff as a matter of law, and there is no other basis for federal jurisdiction either alleged or available, this case must be dismissed for lack of subject matter jurisdiction under Fed. R. Civ. P. 12(b)(1).

IT IS THEREFORE ORDERED that the defendant's motion to dismiss for lack of jurisdiction (docket #25-2) is GRANTED.

IT IS FURTHER ORDERED that all other pending motions (docket #5-1, #8-1, #12-1, #16-1, #18-1, #25-1) are DENIED as moot.

ENTER THIS 6th day of October, 1992.

/s/ Harold A. Baker
HAROLD A. BAKER
United States District Judge

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT
Chicago, Illinois 60604

March 9, 1994

Before HONORABLE WILLIAM J. BAUER,
Circuit Judge
HONORABLE MICHAEL S. KANNE,
Circuit Judge
HONORABLE ILANA DIAMOND ROVNER,
Circuit Judge

No. 92-3678

ABBAS ASSAR, M.D.,
Plaintiff-Appellant,
v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE and CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION (CIMRO),
Defendants-Appellees.

Appeal from the United States District Court
for the Central District of Illinois, Danville Division
No. 92 C 2161—Harold A. Baker, Judge

ORDER

On consideration of the petition for rehearing filed by plaintiff-appellant on January 11, 1994, all of the judges on the original panel having voted to deny the same,

IT IS HEREBY ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

APPENDIX D

REGULATIONS INVOLVED

Subpart C—PRO Responsibilities

§ 1004.50 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that—

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanctions the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 1004.60.

§ 1004.70 PRO report to OIG.

(a) *Manner of reporting.* If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the original office with jurisdiction.

(b) *Content of report.* The PRO report must include the following information—

(1) Identification of the practitioner or other persons and when applicable, the name of the director, administrator, or owner of the entity involved.

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries or oral exchanges with the practitioner or other person regarding the violation;

(6) The PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers' and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report—

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

Subpart D—OIG Responsibilities

§ 1004.90 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether—

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *Exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 1004.100(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 1004.100(a) through (c).